NOTE: Sample health form that can be adapted for use by local advisors

_____ FAMILY, CAREER & COMMUNITY LEADERS OF AMERICA
(local chapter name) **Medical Release Form**

I, _____ of _____
Parent/Guardian Name Address
_____ am the _____ of _____
City State ZIP Relation Member's Name
of _____ .
City State ZIP

I hereby give my consent, in the event all reasonable attempts to contact me have been unsuccessful, for immediate medical treatment as required in the judgment of the attending physician while _____ is absent from home _____ to _____.
date date

Member's Date of Birth: _____ Social Security Number (optional): _____

Parent/Guardian Phone Number(s): Work:(____)_____ (____) _____

Home:(____) _____ (____) _____

Family Physician: _____ Family Dentist: _____

Address: _____ _____
Street Street

_____ _____
City State ZIP City State ZIP

Phone:(____) _____ (____) _____ (____) _____ (____) _____
Work Home Work Home

Medical Insurance Company _____ Policy Number: _____

Name of Insured: _____

The following information is needed by any hospital or practitioner not having access to a medical history:

Allergies: _____

Medication being taken: _____

Date of last tetanus shot: _____

Physical impairments: _____

Other pertinent facts to which physician should be alerted: _____

_____

_____

(over)

If parent/guardian cannot be reached in case of emergency, call:

_____ (_____) _____
First Choice Name Area Code Phone

_____ (_____) _____
Second Choice Name Area Code Phone

In a medical emergency, I consent to the local/state advisor or appointed agent, his, her or their discretion in using, taking, arranging for or consenting to the procedures or treatment.

I agree to indemnify and hold harmless the _____ Family, Career and Community Leaders of America, the individual members, agents, employees and representatives thereof, for any and all claims, demands, actions, rights of action, and/or judgments by or on behalf of the above named member arising from or on account of said procedures and/or treatment rendered in good faith and according to accepted medical standards.

I assume the total financial responsibility for the above named member and will not hold the _____ Family, Career and Community Leaders of America responsible in the event of a medical emergency.

_____ _____
Signature of Parent/Guardian Date

_____
Social Security Number of Parent/Guardian (optional)